



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

Respondent Name

Security National Insurance Co

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-10-3886-01

MFDR Date Received

May 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The appeal process has been established to ensure that any errors and/or mistakes made by the carrier or the provider could be corrected and resolved in accordance with rules and guidelines established by the Division. Provider realized its mistake and corrected it, carrier should have taken it under consideration and additional reimbursement should have been warranted."

Amount in Dispute: \$3,860.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier contends that it has calculated reimbursement correctly."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 18867, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2009	Outpatient Hospital Services	\$3,860.87	\$1,612.88

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 12, 2009

- 100 ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE
- 113-001 NETWORK IMPORT RE-PRICING, - CONTRACTED PROVIDER.
- 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement,
- 595-001 THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- W1 Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated August 27, 2009

- 100 ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE
- 113-001 NETWORK IMPORT RE-PRICING, - CONTRACTED PROVIDER.
- 45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement,
- 595-001 THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- W1 Workers Compensation State Fee Schedule Adjustment

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code (100) ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE, (113-001) NETWORK IMPORT RE-PRICING, - CONTRACTED PROVIDER, and (45) Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.” Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 28, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the healthcare provider had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required.

- The notice does not include the start date and any end date during which the insurance carrier had been given access to the contracted fee arrangement as required by §133.4(d)(2)(B).
- No documentation was found to establish time of notification in accordance with §133.4(f).

The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds no request for separate reimbursement of implantables. Nor did the requestor certify that the amount billed represents the actual costs for the implantables in accordance with §134.403(g)(1). Reimbursement will therefore be calculated at 200 percent of the Medicare facility specific reimbursement amount, including any outlier payments, as specified in §134.403(f)(1)(A).
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are

publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code C1778, date of service June 1, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80047, date of service June 1, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$12.36. 125% of this amount is \$15.45. The recommended payment is \$15.45.
- Procedure code 36415, date of service June 1, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
- Procedure code 85027, date of service June 1, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.45. 125% of this amount is \$11.81. The recommended payment is \$11.81.
- Procedure code 63655, date of service June 1, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0061, which, per OPPS Addendum A, has a payment rate of \$5,476.61. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,285.97. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$3,225.51. The non-labor related portion is 40% of the APC rate or \$2,190.64. The sum of the labor and non-labor related amounts is \$5,416.15. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.24. This ratio multiplied by the billed charge of \$5,100.00 yields a cost of \$1,224.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$5,416.15 divided by the sum of all APC payments is 98.04%. The sum of all packaged costs is \$10,065.67. The allocated portion of packaged costs is \$9,868.83. This amount added to the service cost yields a total cost of \$11,092.83. The cost of these services exceeds the annual fixed-dollar threshold of \$1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is \$1,614.57. 50% of this amount is \$807.29. The total APC payment for this line, including outlier payment, is \$6,223.44. This amount multiplied by 200% yields a MAR of \$12,446.87.
- Procedure code 95972, date of service June 1, 2009, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0692, which, per OPPS Addendum A, has a payment rate of \$109.24. This amount multiplied by 60% yields an unadjusted labor-related amount of \$65.54. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of \$64.33. The non-labor related portion is 40% of the APC rate or \$43.70. The sum of the labor and non-labor related amounts is \$108.03. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,800. The outlier payment amount is \$0. The total APC payment for this line is \$108.03. This amount multiplied by 200% yields a MAR of \$216.06.
- Procedure code 76000, date of service June 1, 2009, has a status indicator of Q1, which denotes STVX-

packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

4. The total allowable reimbursement for the services in dispute is \$12,693.94. This amount less the amount previously paid by the insurance carrier of \$11,081.06 leaves an amount due to the requestor of \$1,612.88. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,612.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,612.88, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	March 13, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.